

**World Vision Relief & Development Inc.**

**MIDTERM EVALUATION REPORT  
SHAMVA CHILD SURVIVAL PROJECT  
WORLD VISION ZIMBABWE**

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Ending Date: September 30, 1994**

Submitted to:

**Child Survival and Health Division  
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## TABLE OF CONTENTS

	<u>Page #</u>
ACRONYMS .....	~
<b>EXECUTIVE SUMMARY</b> .....	1
1. ACCOMPLISHMENTS ..	2
2. RELEVANCETO CHILD <b>SURVIVAL PROBLEMS</b> .....	3
3. <b>EFFECTIVENESS</b> .....	4
4. RELEVANCETO DEVELOPMENT .....	8
5. DESIGN AND IMPLEMENTATION .....	9
Design .....	9
Management and Use of Data .....	9
Community Education and Social Promotion .....	11
Human Resources for Child Survival .....	12
Supplies and Materials for Local Staff .....	15
Quality.. .....	16
Supervision and Monitoring .....	16
Use of Central Funding .....	17
PVO's Use of Technical Support .....	18
Assessment of Counterpart Relationships .....	19
Referral Relationships .....	20
PVO/NGO Networking .....	21
Budget Management .....	21
6. SUSTAINABILITY .....	23
7. RECURRENT COSTS AND COST-RECOVERY MECHANISMS .....	25
8. <b>RECOMMENDATIONS</b> .....	26

## ACRONYMS

<b>AHC</b>	Area Health Coordinator
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>ARI</b>	Acute Respiratory Infection
<b>BCG</b>	Bacillus Calmette Guerin (tuberculosis vaccine)
<b>CBD</b>	Community-Based Distributor
<b>c s</b>	Child Survival
<b>CSP</b>	Child Survival Project
<b>CSFP</b>	Child Supplementary Feeding Program
<b>DIP</b>	Detailed Implementation Plan
<b>DNO</b>	District Nursing Officer
<b>DPT</b>	Diphtheria, Pertussis, Tetanus
<b>EHT</b>	Environmental Health Technician
<b>EPI</b>	Expanded Program on Immunization
<b>FHW</b>	Farm Health Worker
<b>FP</b>	Family Planning
<b>GM</b>	Growth Monitoring
<b>HIS</b>	Health Information System
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information, Education, and Communication
<b>IGA</b>	Income-Generating Activity
<b>K&amp;P</b>	Knowledge and Practices (survey)
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Nongovernmental Organization
<b>ORS</b>	Oral Rehydration Solution
<b>ORT</b>	Oral Rehydration Therapy
<b>PDO</b>	Program Development Officer
<b>PHC</b>	Primary Health Care
<b>PMD</b>	Provincial Medical Director
<b>PNO</b>	Provincial Nursing Officer
<b>PVO</b>	Private Voluntary Organization
<b>RHC</b>	Rural Health Clinic
<b>SCF</b>	Save the Children Fund
<b>SCN</b>	State Certified Nurse
<b>s s s</b>	Sugar, Salt Solution
<b>TM</b>	Traditional Midwife
<b>TOT</b>	Training of Trainers
<b>TT</b>	Tetanus Toxoid
<b>USAID</b>	United States Agency for International Development
<b>VCW</b>	Village Community Worker
<b>WCBA</b>	Women of Childbearing Age
<b>WHO</b>	World Health Organization
<b>WVRD</b>	World Vision Relief & Development
<b>WVZ</b>	World Vision Zimbabwe
<b>ZNFPC</b>	Zimbabwe National Family Planning Council

## EXECUTIVE SUMMARY

A midterm evaluation of the Shamva Child Survival Project (CSP) in Zimbabwe was conducted from September 10-22, 1993, at a cost of approximately \$11,000 (including survey cost). The evaluation team included the following members:

Alethea Mashamba	Health Information Officer, The World Health Organization (WHO)
Dr. Richard Munochiveyi	Mashonaland Central Provincial Medical Director, Zimbabwe Ministry of Health (Team Leader)
Sibonginkosi Mushapaidze	Health Manager, Technical Support Services Division, World Vision Zimbabwe (WVZ)
Tom Ventimiglia	Program Development Officer, WVRD
Cordelia Zvavamwe	District Nursing Officer (DNO), Mt. Darwin District, Zimbabwe Ministry of Health

All members contributed to the writing of this report and participated in debriefing sessions with the WVZ national director, former acting national director, and associate director for field ministries. Evaluation findings were also shared with project staff and management, provincial MOH staff, Shamva District Health Authorities, and the district administrator. A half-day meeting to share survey results with project and MOH staff will be facilitated by the project consultant.

The evaluation consisted of interviews with staff from the project, Ministry of Health (MOH), and WVZ field office and with members of the community; focus group discussions with community members and community-based health workers; field visits to the project office, the provincial MOH offices, two randomly selected rural health clinics (RHCs), one of the rural hospitals, one outreach center, and a farming community; review of project documents and records; and a 30-cluster sample Knowledge and Practices (K&P) survey (conducted from August 6-16, 1993).

Technically the CSP is sound and has achieved many of its objectives. Specifically, the project has trained all RHC staff as trainers and has trained all VCWs and FHWs on use of the HIS; objectives related to growth monitoring and reduction of malnutrition have been exceeded; objectives related to immunization coverage and use of contraceptives were nearly met. There are a number of unquantified indicators of achievement as well, including steadily increasing community interest and participation.

The key feature of the project-its integration with the services and infrastructure of the MOH-has facilitated project entrance into the community, improved cost effectiveness, and promoted prospects for sustainability. However, several factors---including internal restructuring, loss of seconded staff, and inadequate communication between WVZ and the MOH-have constrained project activities and progress in several areas.

Key recommendations address a number of the primary needs of the project, including the improvement of certain aspects of project management, financial monitoring, supervision, technical support, and communication.

# 1. ACCOMPLISHMENTS

The Shamva Child Survival Project was originally intended to begin in October 1991 but has been implementing CS interventions only since the second quarter of FY92, or for a period of approximately 20 months.

Measurable project **inputs** through July 1993, according to the annual report and the monthly and quarterly reports from FY93, include the following:

- Seventy-nine workshops or training sessions ranging from one day to six weeks in length have been conducted (see section 5.4).
- Over 100 community-based workshops on different CS interventions have been conducted.
- Thirty-one mobile outreach clinics have been established.
- Two KAP surveys have been conducted.

Table 1 shows the measurable **outputs** achieved by the project through July 1993 according to project records, and Table 2 (in section 3) compares progress made in project **outcomes** relative to established objectives.

**Table 1 - Project Outputs (October 1992 - July 1993)**

Indicator	Achievement		
	FY92	FY93	Total
Number of children 0-11 months fully immunized	2,832	2,098	4,930
Number of children 12-59 months fully immunized	345	218	563
Number of WCBA receiving second or higher dose of TT	3,035	4,174	7,209
Average number of children weighed each month:			
1. 0-23 months	3,100	2,068	5,168
2. 24-59 months	1,171	798	1,969
Number of pregnant women making a first ANC visit	3,449	3,678	7,127
Number of repeat ANC visits made	10,827	*7,092	17,919
Number of mothers making a postnatal care visit within six months of delivery	1,114	1,160	2,274
Number of new FP clients seen	1,644	1,403	3,047

Indicator	Achievement		
	FY92	FY93	Total
Number of FP visits made by previous clients	11,722	*12,616	24,338
Number of oral contraceptives issued			
1. Lofemenol	15,755	22,854	38,609
2. Ovrette	17,150	24,184	41,334
Number of condom strips distributed	41,380	36,377	77,757

\* Missing data from June 1993

Estimates obtained from the survey sample indicate that the project has reached approximately **90** percent of children under two years (in the growth monitoring and immunization components). Project records indicate that in FY92 over 80 percent of children under one were immunized, and from October 1992 to June 1993 over 65 percent of the 3,212 infants have been fully immunized. No records are available which accurately reflect the percentage of the 14,650 children under five or the 20,016 WCBA who have been reached, but best estimates by the PMD put the figures at 80 percent and 60 percent, respectively.

## 2. RELEVANCE TO CHILD SURVIVAL PROBLEMS

### Major Causes of Mortality and Morbidity

The major causes of child mortality and morbidity in the project service area remain as they were at the time the project proposal and Detailed Implementation Plan (DIP) were written—diarrhea diseases, malnutrition, malaria, respiratory infections, and perinatal causes. MOH and project staff believe that HIV/AIDS may be playing an increased role in the causes of childhood mortality and morbidity, but no concrete assessment of this has been made.

### CS Interventions and Activities

Since the initiation of the project, 31 outreach centers have been established throughout the district to increase community access to a range of primary health care (PHC) services. Project staff, together with those from the MOH, visit each of the outreach centers approximately once a month, where the following child survival (CS) interventions are provided: growth monitoring of children under five years, immunization of children, health education for mothers, and provision of oral contraceptives and condoms. Such services are also being provided at some 17 fixed health facilities (including 15 clinics and two rural hospitals).

The project provides logistical, supervisory, and resource support to the rural health clinics (RHCs) and hospitals in the district, and provides transport of food in support

of the MOH's Child Supplementary Feeding Program (CSFP), which involves screening of children for signs of malnutrition and providing food supplements. In collaboration with the MOH, project staff have trained many of the clinic-based MOH staff as trainers and have conducted numerous training workshops for a variety of community-based health workers.

The community-based health workers used in project activities include Village Community Workers (VCWs) in the communal and resettlement areas, Farm Health Workers (FHWs) on the farms, plus environmental health technicians (EHTs), traditional midwives (TMs), and Community-Based Distributors (CBDs) throughout the project area. They are supported by the project in their health promotion activities at the community level, which focus on the following: education on nutrition, use of ORT, child spacing, and the prevention and management of ARI; growth monitoring; distribution of FP supplies; promotion of personal and environmental hygiene, including construction of latrines, digging of wells and garbage pits, etc.; disease surveillance; and motivation of communities to attend outreach centers and clinics.

The project has also provided orientation and training to a variety of community leaders who in turn educate and encourage community members to participate in CS activities. Recently, the project has provided resources and technical support for community groups initiating income-generating activities (IGAs) and is supporting community-based efforts to construct waiting mothers' shelters and a preschool.

Project activities were designed based on results from the baseline survey, findings from focus group discussions, needs identified by the MOH, and past experiences in Child Survival from another WV project in Zimbabwe. These considerations, together with the integration of activities into the MOH structure and services, have helped to ensure an appropriate focus of activities.

### 3. **EFFECTIVENESS**

Table 2 illustrates, where possible, the achievements of the project relative to stated objectives. Unfortunately, measuring such progress is difficult, for a number of reasons:

1. Several objectives are not defined clearly (e.g., "70 percent of WCBA will know the signs and symptoms of **ARI**") and are thus not easy to measure.
2. Some indicators do not have baseline figures (e.g., "The number of children under one year not receiving weaning foods by the age of four months will be reduced by 50 percent") and so cannot be measured.
3. Many indicators were not measured at all either in the baseline survey, the midterm survey, or both.
4. Some indicators were measured differently at baseline than at midterm and the methodologies used were different, so results are not entirely comparable. (This may

partially explain why some indicators are at lower levels at midterm than those found at baseline.)

5. Some indicators are very difficult to measure (e.g., percent of WCBA receiving education on hygiene and sanitation) and have therefore not been.

Of those objectives which can and have been measured, success has been mixed. Objectives were nearly met or were surpassed in the areas of growth monitoring, malnutrition reduction, contraceptive use, immunization of children, referrals for ARI, and training. Others, including IT immunizations, management of diarrheal diseases, extended breast-feeding, and delivery at health facilities were clearly not met based on the results from the sample chosen.

**Table 2 - Comparative Summary of Achievements**

Indicators	Baseline	Mid term	Target to Date
A. immunization			
1. Percent of children fully immunized before their first birthday	84	79	90
2. Percent of children 12-59 months fully immunized	NA	NA	87
3. Percent of WCBA having received two doses of TT (of those with a card)	63	38	68
4. Percent of mothers knowing the correct age for administration of measles vaccine	80	73	90
B. Control of Diarrheal Diseases			
1. Percent of cases of diarrhea in children under five managed at home with SSS	≈74	34	95 (EOP)
2. Percent of WCBA demonstrating correct knowledge of the preparation and use of SSS	49/62	NA	85 (EOP)
3. Percent of WCBA receiving education on hygiene and sanitation	NA	NA	90 (EOP)



Indicators	Baseline	Midterm	Target to Date
<b>C. Nutrition</b>			
1. Percent of children under two participating in monthly weighing sessions	NA	88	<b>80</b> (EOP)
2. Percent reduction in the number of children under five with weight for height under the third percentile line	-	52	25 (EOP)
3. Percent of mothers breast-feeding for 24 months	NA	<b>33 (N=9)</b>	<b>90</b> (EOP)
4. Percent reduction in children not receiving weaning foods by the age of four months	-	NA	50 (EOP)
5. Percent of WCBA involved in the SFPP	21	NA	50 (EOP)
<b>D. Maternal Care</b>			
1. Percent of mothers delivering at a health facility	68	58	<b>80</b> (EOP)
2. Percent of mothers attending at least one postnatal care session	43	NA	60 (EOP)
3. Percent of WCBA using a modern method of FP	<b>≈70</b>	76	85 (EOP)
<b>E. ARI</b>			
1. Percent of WCBA who know the signs and symptoms of ARI (at least one)	NA	94	70 (EOP)
2. Percent of mothers with children having moderate to severe ALRI who seek medical care	NA	73	80 (EOP)
3. Percent of mothers with children having mild ALRI who provide proper home management	NA	NA	90 (EOP)
<b>F. HIV/AIDS</b>			
1. Percent of <b>WCBA</b> knowing three modes of HIV transmission	NA	<b>NA</b>	<b>80</b> (EOP)
2. Percent of WCBA knowing that there is no AIDS cure	84	NA	<b>100</b> (EOP)

Indicators	Baseline	Midterm	Target to Date
3. Percent of couples using condoms	5	NA	50 (EOP)
<b>G. Training/Social Mobilization</b>			
1. Percent of RHC staff trained as trainers	0	100	95 (EOP)
2. Number of VIDCOs with a health committee	0	NA	(EOP)
3. Number of VIDCOS with 10 people trained as mobilizers	0	NA	(EOP)
4. Percent of VCWs and FHWs trained on data collection and reporting	0	100	95 (EOP)

NA = not available or measurable  
 - = not applicable

≈ = approximate figure  
 EOP = end of project

### Constraints to Meeting Objectives

The simplest constraint to meeting some of the objectives is that they were set at rather ambitious levels, as the DIP technical review pointed out. Additionally, it should be noted that very few midterm benchmarks were set in the DIP, so results are being compared in the majority of cases to end-of-project objectives. Other key constraints are related to difficulties in project staffing, management, supervision, and communication, all of which are discussed in detail later in this report. Additional constraints include the following:

- Inadequate numbers of community-based health workers, particularly in the farming areas;
- Delays in hiring staff and relocation of project staff to the project site;
- Unavailability of transport for community members to outreach centers or clinics;
- Drought itself, as well as the concomitant drop in outreach attendance;
- Resistance of a portion of the community to receiving health services on religious grounds;
- Low levels of literacy and income.

## **Recommendations**

- a. A thorough review and revision of objectives needs to be made, with the purpose of ensuring that they are measurable and that they reflect the activities and achievements of the project.
- b. Technical assistance should be sought in the design of the final K&P survey questionnaire to ensure that all indicators are measured appropriately and that some measure of comparability in results with previous surveys is obtained.

## **4. RELEVANCE TO DEVELOPMENT**

The main barriers to meeting basic health needs of children include the following: the remoteness of the area and consequent difficulty in accessing health services, low levels of income and literacy, a lack of access to safe water, and drought.

The project has taken several steps to improve the ability of community members to participate and benefit from CS activities. The most important ones include establishing 31 outreach centers spread throughout the district, strengthening the skills and supporting the activities of a variety of community-based health workers, and increasing awareness among community members of the maternal and child health services available in the area.

A considerable amount of community education, provided both at outreach centers and in the communities, has increased knowledge about and demand for the full range of CS interventions. Project and MOH staff, along with community-based volunteers, motivate community members to participate in project activities; orientation and training of community leaders to promote the activities of the project has been a particularly effective measure.

The project has begun to take a number of steps to address some of the other barriers mentioned above. For example, in FY93 three community-initiated IGAs were provided with loans to supplement their own start-up funds, with a goal of increasing household income for meeting basic health needs. The project has also funded one nutrition garden as part of its supplemental food production program. Community-initiated efforts to construct waiting mothers' shelters at two of the health facilities in the area have been supported, and the project has budgeted support for construction of preschools in response to requests from the community. In both of these latter efforts, communities have already contributed and transported materials for construction.

## **Recommendations**

- a. The project should act as a liaison between the community and the Ministry of Public Construction to speed up the process of obtaining official clearance for the construction of waiting mothers' shelters and other structures.
- b. Project management should ensure that adequate technical support and supervision for the IGA component and revolving loan scheme is obtained,

either from the relevant WVZ department or from appropriate external sources.

## **5. DESIGN AND IMPLEMENTATION**

### **5.1 Design**

#### **Expansion of Project Area and Services**

By gradually increasing the number of outreach centers to the current 31, project activities were expanded geographically so that the entire district, including an estimated 93,938 people, is now being covered. Similarly, training activities of the project first targeted MOH nurses and EHTs, who were trained as trainers, and this cadre have been supported in subsequently training community leaders and community-based health workers. These workers in turn educate the community at large and motivate them to participate in activities promoting health. In this way, the target population has been carefully and appropriately expanded.

#### **Objectives**

The project set a number of objectives for outputs as documented in the DIP, and difficulties with the project's objectives are detailed in Section 3. Based on recommendations made in the technical review, two objectives have been revised since the writing of the DIP.

#### **Willingness of Management to Make Changes**

Project staff have demonstrated considerable flexibility to meet changing conditions and to accommodate requests for assistance from the MOH. For example, the project interrupted its regular activities to join with the MOH in its mobilization and education campaign during a cholera outbreak in 1993, as well as to assist at cholera treatment centers. As another example, the project changed its original plans to initiate supplementary feeding programs at the RHCs after the MOH announced plans to start the national CSFP in response to the drought. Project staff helped to plan for the program in Shamva district, and project vehicles are providing transport for food purchased by the MOH.

### **5.2 Management and Use of Data**

The project's health information system (HIS), which has been described in detail in the first annual report, is a combination of the system used nationally at the clinic level and above and a recently implemented project-specific community-level HIS that allows project and MOH staff to identify and monitor at the community level (a) specified high-risk groups, such as low-birth-weight babies and children who are losing weight or are below standard weight and (b) disease outbreaks. Overall, the system is comprehensive and gives a good picture of the health status and needs of the project area.

## **Utilization of Data in Decision Making**

Project staff have been able to utilize certain data for making decisions and taking action. For example, data collected by community-based health workers helped to establish the existence of the cholera epidemic, as well as periodic diarrhea outbreaks. This allowed early interventions at the community level and increased chances for effective control.

Project staff are also aware of a number of other potential uses for data collected through the HIS. These include, for example, identifying communities with lower coverage or otherwise in relatively greater need of increased services or access, in order to plan outreach; identifying and tracking immunization defaulters; and as a learning tool for community-based workers, familiarizing them more completely with health problems and needs in their areas.

## **Functional Capacity of the HIS**

Unfortunately, the HIS at community level has only recently been implemented and is not yet fully functional. Staff at the RHCs collect the data from the community-based workers but are simply forwarding it to project staff at the district level. The project coordinator is not analyzing any of the data received from the community level, primarily because only an estimated 50 percent of data collectors are submitting their reports on time. This is due to a combination of factors, including:

- a. The system is still new and perhaps not well understood by some of the data collectors;
- b. Reports from the community-level workers are expected each week, which is difficult for many to accomplish both in terms of their workload and simply in finding transport;
- c. The data collectors themselves do not know the reasons for which they are collecting data, are not given feedback on it, and do not use it themselves, so they have little motivation to make sure it is collected correctly and on time.

Recognizing some of these difficulties, the project has planned some revisions and will continue providing refresher training for those in need.

## **Sharing of Information**

Other components of the project's HIS, aside from this routine data collection, include monthly and quarterly reports and surveys. The monthly reports, which discuss achievements and constraints, summarize statistical information, and update the status of the budget and expenditures, are compiled by the project coordinator and submitted to the project manager as well as to WV headquarters (WVRD). These reports have not been going routinely to the project's technical consultant, however.

## **Surveys for Monitoring and Evaluation**

Two K&P surveys, following a 30-cluster sampling methodology, have been conducted—one at baseline and one in August 1993 as part of the midterm evaluation. The results of the baseline survey were used to prioritize and plan project activities, revise objectives and yearly benchmarks, and assist in the identification of training needs. Focus group discussions conducted at the same time as the survey comprise the only qualitative data collection thus far and were also used to identify areas of need (e.g., construction of waiting mothers' shelters, support for IGAs). Results of the midterm survey will be used to assess project progress and identify areas of need for the remaining year of project implementation.

## **Recommendations**

- a. Additional training on the HIS, particularly on the analysis and utilization of data collected, should be provided to all staff, including project as well as clinic- and community-based staff.
- b. Technical assistance in revising the community-based HIS should be continued and should also focus on improving the new EPI outreach registers to enable their use in tracking immunization defaulters.

### **5.3 Community Education and Social Promotion**

Health promotion/social mobilization is a key component of project activities. Health education precedes the provision of health services at the outreach clinics and is given as well at the RHCs. In addition to a large number of community-leaders, all cadres of community-based health workers have been trained in the CS interventions (see section 5.4) and provide ongoing education of community members at the village level. These groups are utilized also to promote the activities of the project and to encourage community participation in them. Over 100 village-level CS workshops have been conducted so far.

In the majority of cases health education is linked to available services, either at the outreach centers or at the health facilities. The main services that could reasonably be made more readily available are the provision of antenatal care (**ANC**) and **TT** immunizations for pregnant women and other women of child-bearing age (**WCBA**). This need was expressed during focus group discussions with mothers.

## **Development of Messages**

The baseline survey and focus group discussions revealed a number of educational needs which have been incorporated into both training of health workers and subsequently into health education of community members. Health education topics are varied and often are determined based on prevailing health problems. The educational messages used, however, are primarily those already developed by the MOH. Similarly, almost all educational materials used by the project have been

developed and supplied by the MOH. Given that these materials and messages have been approved for use by the partner agency, project staff adopted them without any pretesting or refinement.

The project staff have shown hints of creativity in their approach to community education, such as in the design of CS T-shirts and use of community drama groups in areas such as HIV/AIDS education. Otherwise, innovation in the IEC area has been limited.

The project has successfully managed to ensure consistency of messages provided to mothers by including for training all levels of health workers, plus community leaders, local government representatives, and even workers from ministries other than health. The evaluation revealed remarkable consistency in messages used by a wide range of such individuals.

The variety of sources from which community members receive messages also facilitates learning, and there is considerable anecdotal evidence that community awareness of CS interventions has increased. One community leader remarked that he has been hearing mothers discussing FP and other health matters with increased frequency, and a key MOH staff member noted, “The communities are now aware that there is more to Child Survival than EPI.”

### **Recommendations**

- a. Outreach services should be expanded to include the provision of ANC for pregnant women and TT immunizations for pregnant women and other WCBA. For privacy, the project should explore low-cost alternatives such as portable screens or a tent, a cot, etc. As a short-term measure, the project should organize and facilitate in-service training for nurses on ANC with the MOH. Consideration should also be given to sending the two project SCNs and selected other nurses for training in midwifery as a longer-term measure.
- b. Selected project staff should attend the ZNFPC-sponsored IEC course or receive other suitable training to enable the project to be more effective and innovative in the development of educational messages and materials and in other aspects of IEC.

## **5.4 Human Resources for Child Survival**

A revised organizational chart for the project is included as Appendix A. With the reassignment of the area health coordinator (AI-K), the project now has positions for eight full-time staff, including the project coordinator, the district project coordinator, two state certified nurses (SCNs), two nurse aides, a secretary, and a driver. The district project coordinator and two SCNs were originally seconded to the project by the MOH and received income supplements from the project budget. In addition to these staff, there is also a part-time bookkeeper and an accountant based at WVZ

in Harare and a part-time driver seconded from the MOH (who has been temporarily relieved of his duties). All staff are local.

In addition to these personnel, the project makes use of a number of other health workers. For example, MOH nurses from the RHCs routinely join project staff in providing immunizations and health education at the outreach centers. VCWs, FHWs, and Red Cross volunteers occasionally also participate during outreach by providing health education or weighing children, and CBDs often distribute FP supplies. In addition, at the community level VCWs, FHWs, TMs, EHTs, and CBDs are all active in educating communities and motivating them to participate in project activities.

### **Adequacy of Staffing**

The primary concern with regard to staffing is the recent loss of the two seconded SCNs. The MOH does not have the resources or staff to replace the nurses, so WVZ has recently made the decision to hire two on its own. In their absence, the project coordinator and district project coordinator have had to participate in outreach activities at the expense of supervision and training. Other training which might have been conducted by the SCNs has also had to be taken over by the coordinators.

In addition to these added duties, the project coordinator has also had to assume a number of managerial and administrative responsibilities since the reassignment of the AHC (see section 5.9). While she has coped admirably with the extra burdens, assistance for her is of critical importance.

### **Community-Level Health Workers**

The community-based health workers are all supported at some level by the MOH or other ministries with the exception of the TMs and Red Cross volunteers. The levels of remuneration are relatively low, however, and the workload of most is heavy. Some, such as the VCWs and FHWs, also have responsibilities with other ministries such as Education and Agriculture, in addition to their health-related activities. Newly added responsibilities related to the collection and reporting of data for the community-based HIS have added considerably to this load.

### **Training**

Most of the facility- and community-based health workers in the district have been trained in a range of activities, both by the project and prior to the project's entrance into the district. Project training of the different cadres of workers has occurred as follows:



**Table 3 - Training Sessions**

Type of Training/Workshop	Type of Participants	Number of Participants	Length	Number of Sessions Held
TOT-Introduction to CSP & its Objectives	Nurses	24	Three days	1
	<b>EHT</b>	9	" "	
	Extension workers	6	One day	1
TOT-EPI	Nurses EHT	24 8	Three days	2
TOT-ARI, <b>CDD</b>	Nurses <b>EHT</b>	14 9	Three days	1
TOT-Safe Motherhood Initiative	Nurses	30	Three days	2
TOT-Health Information System	Nurses EHT <b>PREHO</b>	30 5 1	One day	2
Health Information System-Data Collectors	VCW FHW CBD	126 46 8	Two days	8
HIS Refresher Course	VCW	10	One day	1
Initial Training for FHW	Untrained FHW	20	Six weeks	1
Initial Training, for TBA	Untrained TBA	56	Two weeks	3
Community Leaders Workshops on Child Survival and the CSP	Political leaders	560	Three days	8
	<b>VCW/CBD</b>	238	" "	8
	<b>FHW</b>	46	" "	1
	Church leaders	347	" "	8
	Traditional midwives	206	" "	8
	Traditional healers	234	" "	8
	Preschool teachers	19	" "	2
	Water subcommittees	189	" "	8
	Teachers	34	" "	2
	<b>Youths</b>	46	" "	1
	Business	21	" "	1
K & P Survey Training	PMD, MOH, Health workers	26	Two days	2

For TOT sessions, results from the baseline survey revealed areas of need and were used to design certain training components. For example, the gap between BCG coverage according to the cards and the percent of children with a BCG scar gave evidence to the need to provide extra training in proper techniques of vaccine administration. Most training, however, was intended to familiarize workers with the

CS interventions both individually and also as a comprehensive system since the concept of comprehensive care is relatively new. Additionally, a considerable amount of training has been related to the use of the HIS.

The training methodology, which is based on adult-learning principles, appears to have been appropriate and was well-received. Given the wide range of topics covered, however, the overall length of training may not have been adequate.

### **Recommendations**

- a. Training, both initial and refresher, should be reorganized so that training sessions concentrate on single interventions for shorter duration (one to two days) rather than on multiple interventions over a longer period.
- b. A dialogue between WVZ and the MOH regarding the possibilities for the MOH absorbing the two SCNs to be hired by the project should begin immediately.

## **5.5 Supplies and Materials for Local Staff**

The project has supplied some materials to community- and clinic-based health workers, including flip charts, notebooks, and forms for the health information system. It also uses and distributes a variety of IEC materials (posters, pamphlets, etc.) supplied by the MOH. Visits to clinics gave evidence that these materials are being used-posters were displayed on clinic walls, flip charts were found out on tables, etc. Other equipment which has been distributed by the project, including refrigerators, hotplates, standing and bathroom scales, etc., are clearly meeting a need, are much in use, and are well-appreciated. In general, the equipment, supplies, and materials needed by health workers are in adequate supply.

Misunderstandings and lack of communication between WVZ and MOH staff have resulted in considerably less than optimal use of some of the equipment purchased by the project, however. For example, video equipment intended for use in training health workers and for health education of community members has been purchased but so far not used at all. Some complaints have been made regarding the appropriateness of the video camera, and project staff feared that the TV monitor would be damaged in the field, but the primary problem has been a lack of agreement between the PVO and the MOH about the use of the equipment.

Similar difficulties have affected the use of other equipment, most importantly the two project vehicles. During the early stages of project implementation, a written agreement governed use of the vehicles, but the agreement was not modified after project staff relocated to the project area from Harare. Unresolved disputes regarding responsibility for the vehicles at that time, plus reports of inappropriate (nonhealth-related) use, resulted in one of them being withdrawn from the project site to be stationed and controlled instead from Harare. This clearly affected, and continues to affect, the operation of the project as the vehicle is frequently delayed

or fails to arrive at all at the project site for scheduled activities. Supervisory visits have been especially affected, since this was the primary purpose for which the vehicle was intended to be used.

### **Recommendations**

- a. The project vehicles and all other project assets should be based at and supervised from Shamva. Clear guidelines regarding their use need to be documented and enforced.
- b. In coordination with the MOH, WVZ should review the appropriateness of the video camera which was purchased in relation to its intended use in project activities. Project management should make the necessary arrangements to have a protective casing constructed for the TV monitor so that it can also be put to use.
- c. Project staff should pursue options for obtaining additional equipment, including thermometers and ice packs, required to ensure proper maintenance of the cold chain during outreach.

## **5.6 Quality**

Project staff at the field level appear to have sound technical knowledge and skills overall. As mentioned in section 5.4, however, the project no longer has adequate numbers of staff required to maintain project activities at the levels sustained prior to the loss of the AHC and the two SCNs.

Based on observations at one outreach clinic, project and MOH staff give appropriate support, counseling, and education to mothers. Health promotion activities were noted to have been given a significant portion of the overall outreach time.

## **5.7 Supervision and Monitoring**

Supervision of the project coordinator, particularly since the reassignment of the AHC, has been minimal. There has been a lack of agreement regarding who-VWZ or the MOH-should be responsible for this supervision, and in the absence of such agreement, it has essentially gone undone. Supervision of staff at the RHCs by the two coordinators has been slightly more regular but subject to frequent interruptions. One of the effects of the loss of personnel mentioned above has been the subsequent need for the two coordinators to involve themselves more fully in service delivery, so their ability to provide planned supervision and training of clinic- (and community)-based staff has declined significantly. Unresolved conflicts regarding the use of the vehicle intended for supervision has also adversely affected the frequency of such visits, as mentioned above.

The supervision of RHC staff includes counseling and joint problem solving, but little in the way of performance evaluation or on-the-job training. Moreover, documen-

tation of supervisory activities, including problems discussed, recommendations made, and follow-up needed, was virtually absent.

Observation of an outreach clinic revealed the need for improved supervision there as well. A number of technical and procedural problems (e.g., breaks in the cold chain, failure to tally immunizations given, requiring mothers to remember her child's weight until reaching the front of the immunization line) could easily be overcome with adequate supervision.

At the community level, there is no evidence of functional health committees taking part in the monitoring or supervision of health activities. Supervision of the health workers at this level comes primarily from RHC staff, including EHTs. Again, however, this supervision was perceived by the health workers themselves to consist primarily of verification of reported accomplishments (e.g., number of latrines constructed) rather than being supportive or instructive.

### **Recommendation**

To ensure quality in the performance of workers at all levels, more consistent supervision with increased emphasis on performance evaluation and on-the-job education appears warranted. Supervision of clinic and outreach staff should be based on clearly defined objectives and should include the use of appropriate checklists for performance evaluation. Such visits must be made more regularly and the findings and follow-up required should be documented. Supervision-specific training for those involved in such activities should be included early in the training schedule for FY94.

## **5.8 Use of Central Funding**

A.I.D. has provided WVRD with a total of \$250,862 in headquarters funding for administrative monitoring and technical support of six CSPs, including the one in Shamva. These funds support the following key activities:

- (i) Preparation and submission of quarterly narrative and financial reports to USAID Washington;
- (ii) Fund-raising for the \$288,280 WV match (44.2 percent of the total budget of \$652,921);
- (iii) Preparation and submission of contracts for consultants;
- (iv) Travel arrangements and/or orientation for project staff attending international conferences and workshops;
- (v) Provision of feedback on technical reports from project staff and clarification of financial, legal, and technical issues related to project implementation; and

- (vi) Distribution of technical articles on CS issues.

In addition to the ongoing communication between the project management and WVRD, three visits to the project have been made by WVRD's program development officer. These trips were for the purpose of providing technical assistance with the development of the project's HIS, providing recommendations regarding the survey methodology, and participating in the midterm evaluation. The PDO also assisted in the writing and editing of the project's DIP and annual report.

## 5.9 **PVO's Use of Technical Support**

In addition to that mentioned in section 5.8, the project has received a significant amount of other technical assistance in the following areas: initial project design, planning and writing the DIP, conducting the baseline and midterm surveys, writing the annual report, designing training curricula, and developing a community-level HIS. Much of this support came from the PMD (who also acts as the project's technical consultant), from the provincial medical officer of health, and from WVZ's area health coordinator. The project has also received technical support from the WVZ Research and Evaluation Associate in the design of the IGA component.

A couple of factors have hindered the ability of project staff to obtain adequate ongoing technical support. The first is a consequence of the internal restructuring at WVZ that resulted in the area health coordinator being reassigned to another division without any direct oversight of project activities. Prior to the restructuring, the AHC was spending approximately 90 percent of her time with the project-providing supervision of field-based project staff, assisting with project reporting, giving managerial and logistical support, and providing input and guidance on technical issues related to project implementation.

With the AHC's departure and with no direct replacement, there is now no person above the level of the project coordinator with a health background who has any direct supervisory, managerial, or supportive oversight of project staff. All of the activities previously conducted by the AHC have had to be assumed by the project coordinator in the field and by the Harare-based project manager. However, several factors, including responsibilities with a number of small-scale development projects in other parts of the country, have limited the amount of support, especially technical, that can be provided by the project manager, who has consequently relied on the MOH to address the technical needs of the project.

Technical assistance from the project consultant has also been limited by the absence of any agreement between the consultant and WV regarding his responsibilities with the project. Consequently, communication between project staff and the consultant has been insufficient, and project technical needs have not always been relayed and/or addressed in a timely fashion or at all. Moreover, the project coordinator expressed some degree of discomfort in communicating needs for technical support to the consultant as an independent party, given that he is also the provincial medical director.

Terms of reference detailing such things as frequency of consultative meetings could have helped to overcome such difficulties. Such terms could also help to avoid any problems obtaining technical assistance anticipated in the upcoming months. This will include input on several initiatives with which the MOH has requested the assistance and cooperation of the project, including control of HIV/AIDS, TB, and cholera. Assistance will also be needed in the refinement of the community-level HIS and in training of supervisors.

### **Recommendations**

- a. Terms of reference detailing the specific responsibilities, frequency of consultation, and compensation for the project's technical consultant should be established.
- b. Monthly and quarterly project reports (including narrative, financial, and statistical sections) should be submitted regularly to the project's technical consultant.

## **5.10 Assessment of Counterpart Relationships**

### **Collaborative Activities**

The main counterpart of the project is the Ministry of Health. The design of the project was to integrate it into the existing health system to support and strengthen the activities of the MOH. Collaborative activities have included the following:

- (i) MOH staff were intimately involved in the planning and design of the project, and the MOH seconded several staff to fill key project positions.
- (ii) MOH staff participate with project staff at outreach centers and share resources and equipment with the project.
- (iii) The project has trained MOH staff as trainers and joins with these trainers to plan and facilitate training workshops for other MOH staff, community-based health workers, and community leaders.
- (iv) The project coordinator and district project coordinator jointly supervise MOH staff at the **RHCs**.
- (v) The project has joined the MOH in a number of special activities, including the CSFP and the cholera prevention and treatment campaigns.
- (vi) The MOH provided office space for project staff.
- (vii) Project and MOH staff jointly commemorated special health days, including World Health Day and World AIDS Day.

Overall, the integration of CS activities into the existing structures, plans, and activities of the MOH has been successful. Given the considerable amount of training that has occurred (and will continue), the heavy involvement of MOH staff in project activities, and the existing technical skills and experience of MOH staff, there is little doubt that these staff have the capacity to continue operation of the CS activities after the withdrawal of project staff, within the constraints of availability of resources and staff.

### **Dialogue With the MOH**

There are fundamental areas of concern regarding the partnership in the project of WV and the MOH, most of which are a consequence of a lack of open communication at many levels. As closely as WV and the MOH have collaborated, no clear terms of reference detailing the roles and responsibilities of staff were ever established.

There has been little to no communication between the higher levels of the MOH concerned with the project and the top levels at World Vision—from September 1992 to the time of the midterm evaluation, for example, though efforts were made, there was not a single meeting between the PMD and the WVZ national director, either the one acting from September 1992 to July 1993 or the present one appointed in July. There has been, therefore, no opportunity to discuss project progress, review plans, resolve problems and misunderstandings, etc. In the absence of such communication, certain key issues needing resolution (e.g., shared use of resources) have not been addressed, though both sides have agreed on the need to do so.

### **Recommendation**

An open dialogue between WVZ and the MOH needs to be established as a matter of priority. Clear terms of reference detailing the roles and responsibilities of the two project partners should be written and agreed upon. Such terms should include (among others) specific guidelines on the supervision of staff and on the shared use of resources such as the vehicles.

## **5.11 Referral Relationships**

In addition to the 31 (mobile) outreach points established since the initiation of the project, there are 17 other fixed health facilities manned by MOH staff where similar activities (immunization, growth monitoring, provision of oral contraceptives and condoms, and health education), plus treatment of minor ailments, take place. For services that cannot be received at the outreach centers and clinics, patients are referred to either of the two rural hospitals in the district, and from there if needed to the provincial hospital. All of these facilities can be reached with public transport.

This referral system has not been altered with the introduction of the project. However, because of the project's role in providing some equipment to the referral sites (e.g., refrigerators, scales, etc.) and in training staff, the system has been

strengthened. Moreover, the project has increased community access to referral sites by providing use of one of the project vehicles as an ambulance in emergencies. It also has plans to assist the communities in constructing shelters at the rural hospitals for high-risk pregnant women waiting to deliver.

### **5.12 PVO/NGO Networking**

There is a relatively limited number of other NGOs working in Child Survival in Zimbabwe, and this has limited the scope of possibilities for networking. The only other NGO active in Shamva district is Save the Children Fund (SCF) UK, who have collaborated with the project in the training of health workers.

The project has benefited from the experience of WVZ at a USAID-funded CSP in Murewa which recently closed. Lessons learned from this project were successfully incorporated into the design of the CSP in Shamva.

### **5.13 Budget Management**

#### **Rate of Expenditures**

As of August 31, 1993, expenditures for the project since inception were \$225,760 (excluding indirect costs) against a budget-to-date of approximately \$338,341 (equivalent to 66.7 percent, or 33.3 percent underspending). In addition to delays in project startup and devaluation of the Zimbabwe dollar relative to the US dollar, the following justifications for the underexpenditure were given:

- (i) Underspending of 34 percent on salaries and benefits is due largely to the transfer of the AHC (whose salary was paid by the project) to another division and to the loss of the two project-paid SCNs;
- (ii) Underspending of 52 percent on training activities is due to the fact that the MOH and SCF UK have both contributed significantly to the costs of training. In addition, much of the planned training was suspended while the project staff concentrated on addressing the cholera outbreak this year;
- (iii) Underspending of 46 percent on travel and repairs is attributed to the comparative newness of the vehicles and minimal repair needs to date;
- (iv) Underspending of 50 percent on supplies is primarily due to the delay in construction of the waiting mothers' shelters due to continuing discussions with the Ministry of Public Construction and National Housing regarding the design of the structures;
- (v) Underspending of 52 percent on office rent and utilities has resulted from overbudgeting (although originally the project did not expect to pay any office rent, it later revised the budget when it was learned that they would have to pay for office space in Harare);



- (vi) Underspending of 93 percent on non-vehicle repairs is due primarily to the absence of repair and service needs and purchase of fewer capital items than expected;
- (vii) None of the budget for communications has been spent since efforts to obtain a telephone line for the project office have so far been unsuccessful; and
- (viii) Underspending of 70 percent on professional services and evaluations is expected to be partially redressed when the costs of the midterm survey and evaluation are included, but continued underspending is still likely.

The project is overspent on capital items by 21 percent, due primarily to the need to pay duty on the two vehicles, a cost which was expected originally to be waived. Because of the overspending on capital items, some budgeted items (e.g., five of ten refrigerators) have so far not been purchased.

In all likelihood, the budget will be underspent, perhaps significantly, at the end of the project. Because of the underspending in most areas, remaining funds should not present a constraint to achieving objectives.

### **Management of the Budget**

Management of the budget has been flexible enough to allow for unexpected changes in programmatic activities-for example, in the project response to the cholera outbreak and in accommodating the MOH request to provide transport of food for the CSFP. This flexibility, however, has been made possible largely because of the underspending, which has left lots of room for maneuvering.

The excessive underspending is evidence of some of the shortcomings found in the management of the budget overall. Knowledge of the project's budget as detailed in the DIP on the part of project management and those involved in financial monitoring was minimal. Another crucial problem relates to delays at management level in responding to requests from staff in the field for funds, resulting in delays in implementing planned activities.

The evaluation also revealed a number of bookkeeping errors-including charging the project twice for the same piece of equipment (for two different items)-and a lack of adequate care in the preparation of the inventory register-several items are listed more than once, some items are not listed at all, and other items are priced incorrectly (e.g., a weighing scale listed at over \$16,000 U.S.). Such inconsistencies are also symptoms of the absence of careful supervision and monitoring.

### **Recommendations**

- a. A replanning and revision of the budget to account for underspending and to accommodate activities and expenditures necessary in the upcoming year should be made immediately in consultation with the financial officer at WVRD.

- b. A separate account at WVZ for the Shamva CSP should be established.
- c. The project's fixed asset inventory needs to be revised to correct errors of duplication, incorrect pricing, omissions, etc. Serial numbers should be used where possible. The project cash book must also be updated to correct for the items incorrectly charged, list each asset purchased with the correct price, etc. Closer supervision of the bookkeeping in the future is needed.

## **6. SUSTAINABILITY**

### **Steps Toward Sustainability**

One of the key components of the project's strategy to promote sustainability of CS activities after project funding ends is the integration of its activities with those of the MOH (see also section 5.10 on collaboration with the MOH). From the initial stages of project planning through each aspect of implementation, project activities have been intended to complement and strengthen those of the MOH. Thus, when project funding ends, it is expected that the MOH will continue the activities on its own, given available resources.

The integration of activities has been largely successful, so that it is difficult in most areas of health delivery and promotion to separate the activities of the project from those of the MOH. While aware of the initiation of outreach centers and intensification of other health activities, many community members did not realize that there was any "project" in existence.

Another key feature of the sustainability strategy, intended to increase the capacity of MOH staff to continue with the CS interventions on their own, is the emphasis on training (see section 5.4). Several staff (nurses and EHTs) have been trained as trainers and then supported as they have in turn trained other cadres. Large numbers of community-based health workers, as well as community leaders, have also received significant amounts of training and are used to mobilize and educate community members. The role of many of these workers in promoting health in their communities has been strengthened by the project, which encourages their participation in other CS activities such as growth monitoring, distribution of FP supplies, etc.

Community mobilization, together with increased levels of knowledge among community members, is likely also to promote sustainability of CS activities by increasing demand for services. Improved awareness of services available, motivation to benefit from them, and desire for their continuation were **all** expressed during focus group discussions at community level during this evaluation.

### **Incentives**

Most community volunteers are supported by the MOH or other ministries, and the MOH staff (other than those seconded to the project) do not receive any financial

incentives from the project. In addition to their regular MOH salary, seconded staff do receive small allowances from the project (these will not continue after project funding ends). All staff and extension workers receive per diems or, more commonly, are reimbursed for expenses incurred during project activities such as outreach clinics, trainings, and surveys. Trained TMs have received TM kits, and all those completing training have received certificates.

Given the need to promote sustainability, as well as the numbers of workers involved, such incentives are generally appropriate. The primary complaint was that MOH staff accompanying project staff on outreach are required to produce receipts for expenses incurred, despite a MOH policy providing for established per diems (depending on the amount of time spent during the activity).

### **Community Involvement**

Mechanisms for community involvement in the project and health system in general exist in the form of clinic and ward health committees, water committees, etc., but the level of activity in such committees varies greatly. Some community members were involved in discussions pertaining to the planning of project activities and writing of the DIP. As mentioned, a number of community leaders, as well as the community-based extension workers, have been trained in CS interventions and assist the project in educating and mobilizing communities to participate in CS activities. Community representatives have also participated in the conduct of both K&P surveys.

### **Institutionalization by Other NGOs**

There is only one other NGO currently working in Mashonaland Central Province, with which WV has collaborated (see section 5.12). SCF is planning to withdraw from the area, however, so no plans to phase over any responsibilities to them have been made.

### **MOH Involvement**

The MOH's involvement in the project is discussed at length in section 5.10 and their plans for continuing CS activities in section 7. As mentioned above, the design of the project has been toward integrating activities into the MOH structure and increasing MOH capacity to assume responsibility for the activities at the project's end. MOH staff at the district and provincial levels are generally pleased with the progress of the project.

Evidence cited by such staff of the project's impact include the following: (a) an outbreak of measles affecting all other districts in the province has been avoided in Shamva, where not a single case has been recorded in the last three months; (b) participation at outreach centers and clinics, even among previously resistant sectors, has increased significantly; and (c) there is noticeably greater awareness in the

community about all CS interventions (this is supported also to some degree by the survey findings).

### **Recommendation**

Staff from WVZ and the MOH should jointly review the project's policy regarding incentives; specifically, the policy on providing per diems for MOH counterpart staff who are involved in project activities such as outreach should be brought in line with the MOH policy for such situations.

## **7. RECURRENT COSTS AND COST-RECOVERY MECHANISMS**

While no explicit calculation of recurrent costs has been done, project staff, as well as those from the MOH, seem to understand what resources will be required to sustain effective CS activities. The primary recurrent costs include vehicle operating and maintenance costs, salaries of staff, and costs associated with training.

**Vehicles:** Of these, the MOH has already pledged to cover costs associated with the operation of vehicles. **Salaries:** Prior to the loss of the two SCNs who were seconded to the project, the MOH had intended to reabsorb them after the project ended. Presently, however, since the MOH has been unable to replace them because of staff shortages, WV is preparing to hire their own staff to fill the positions. The MOH is considering the possibility of assuming responsibility for the salaries of these two staff (as well as the other WV project staff) following the withdrawal of WV, but no agreement has yet been made. **Training:** At least a portion of training costs will continue to be covered by the MOH. In this area, as with support for outreach services, supervision, etc., it is expected that the intensity of activity will necessarily decrease once the MOH assumes full responsibility for all CS interventions.

### **Community Contributions**

Communities currently contribute to the cost of preventive and promotive activities in a number of ways. As mentioned, the community leaders whom the project has trained in CS interventions and in social mobilization are currently very active in motivating communities to participate in CS activities and are expected to remain so. Additionally, most communities have been active in the improvement of environmental sanitation by building latrines, digging wells, digging garbage pits, etc. Communities have already contributed materials and labor for the construction of waiting mothers' shelters at the two rural hospitals, and these shelters are expected to reduce mortality related to the lack of transport and adequate care for high-risk deliveries in more remote areas. Finally, it is hoped that project support for community-based IGA groups will increase the ability of some to contribute to preventive and promotive health costs.

## **Cost-Recovery and Reduction**

At the current time, no specific mechanisms for cost-recovery have been implemented to offset project expenditures. MOH policy stipulates that individuals earning in excess of \$Z 400 per month are required to pay for health services, but the majority of those in the project area are unable to pay.

The project has made a number of efforts to minimize costs, including the use of local staff and consultants, relocation of staff to the project site, use of MOH staff and other existing health extension workers, securement from the MOH of rent-free office space, and sharing of training costs, including accommodations, with the MOH and with another NGO (SCF). Given the nature of the project area and the relatively large number of beneficiaries (including nearly 15,000 children under five and over 20,000 WCBA), overall costs have been quite low.

Even given the relatively low costs associated with the project, however, some costs are still not likely to be sustained. These include the incentives for seconded staff; support for IGAs, construction of waiting mothers' shelters and preschools, and the supplemental food production project; the frequency and/or number of outreach centers; and the number of training sessions and workshops.

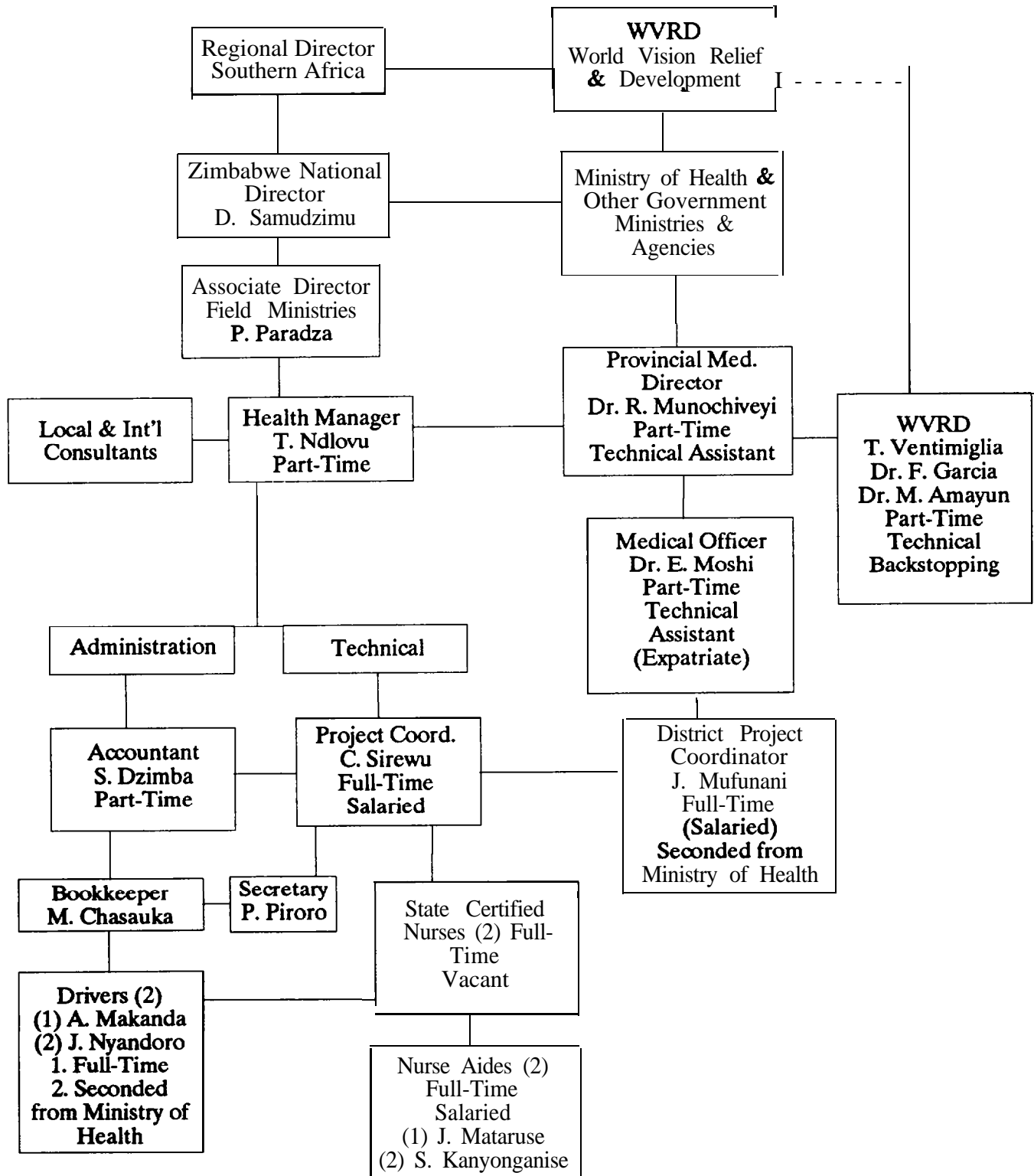
## **8. RECOMMENDATIONS**

Recommendations from the evaluation team have been included in the relevant sections of this report. Two key recommendations which apply generally to the project are as follows:

- a. Project management, supervision, and technical support must be improved substantially. Given the size of the project and its technical nature, the preferred option would be to assign responsibility for the project to the Technical Support Services Division rather than Field Ministries. A second option would be to assign a manager with a health background or experience to the project.
- b. A one-year no-cost extension for the project should be requested from USAID provided that the recommended terms of reference between WVZ and the MOH are agreed upon and that improvements in project management in the areas of finance, supervision, and technical support can be demonstrated.

## APPENDIX A

### SHAMVA CHILD SURVIVAL PROJECT: ORGANIZATIONAL CHART



## **APPENDIX B**

### **List of Persons Interviewed**

1. Ephraim Dhlembeu, former Acting National Director, WVZ
2. David Samudzimu, National Director, WVZ
3. Themba Ndlovu, Project Manager, Shamva CSP, WVZ
4. Caroline Sirewu, Project Coordinator, Shamva CSP
5. Joslyn Mufunani, District Project Coordinator, MOH (seconded)
6. Dr. Edward Moshi, Provincial Medical Officer for Health, MOH
7. Moses Chasauka, Bookkeeper, Shamva CSP, WVZ
8. Nomusa Ndlovu, Acting Finance Manager, **WVZ**
9. Julia Musarndza, Farm Health Worker
10. C. Muchakati, SCN, Chindunduma Primary School Clinic
11. Shylet Ziteya, SCN in Charge, Chindunduma
12. N. Chindeza, SCN in Charge, Bushu District Council Clinic
13. E. Musariri, SCN, Bushu District Council Clinic
14. Rudo Ganda, District Nursing Officer, Shamva District MOH
15. Cathrine Rwodzi, Provincial Nursing Officer, Mashonaland Central Province MOH
16. Norman Madziva, Assistant District Administrator
17. Simon Mataba, Environmental Health Technician
18. Chief Bushu, Bushu Communal Lands